U.S. SENATE COMMITTEE ON
Finance
SENATOR CHUCK GRASSLEY, OF IOWA - CHAIRMAN
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Floor Statement of U.S. Senator Chuck Grassley, of Iowa
"Medicare Part D Is Working — If It Ain't Broke, Don't Fix It"
Senate Committee on Finance
Monday, January 8, 2007

Mr. President, I rise to speak about the Medicare prescription drug benefit.

In the near future, Congress will consider some fundamental changes in how the benefit works. It's important for the public and for Medicare beneficiaries to understand the proposed changes. And it is equally important that we explore the effect that these changes would have. So I will be doing what I can to explain what this debate is about.

First, everyone should recognize that political opponents of the drug benefit have done -- and continue to do -- everything they can to tear apart the new benefit. They have done that since the ink was barely dry on the Medicare Modernization Act in 2003.

First they said that no plans would offer the new drug benefit. Then when it was up and running they said there were too many plans. They said that it was too confusing-that seniors would not be able to choose a plan. But they have enrolled and surveys show that they're satisfied with their with their plans. They suggested that plans could change their prices and the drugs they cover at the drop of a hat, which is not the case. They tainted beneficiaries' views of the benefit before it even got off the ground.

As we have all heard over and over, one of the biggest criticisms about the drug benefit is that the government does not negotiate with drug makers for lower prices. Opponents have gone to great lengths to make it sound like nobody is negotiating with the drug companies. It is correct, of course, that the Secretary himself does not negotiate with drug companies. It is absolutely not correct to say that there is no negotiation. That's complete nonsense.

The idea behind the drug benefit is that multiple drug plans would compete with each other to get the lowest prices from manufacturers - to be the best negotiator - and to offer beneficiaries the best possible drug plan. The plans would strive to have a lower premium, lower drug prices and enhanced benefits. They would strive to be the plan that beneficiaries wanted to join. And if beneficiaries don't like the job their plan is doing, they can fire them. They can go enroll in a better plan.

You see, it is actually very simple. Harnessing the power of competition among plans gives the Medicare program, beneficiaries, and taxpayers access to better negotiators than anything the government could do on its own. But the opponents of the drug benefit don't like that. They want the government itself doing the negotiating. They find it hard to believe that

anyone could do a better job negotiating than big government.

Last week on the Senate floor, the Senator from Illinois said that the law "took competition out of the program so that [the drug companies] could charge what they want." Took competition out of the program? Competition is what this program is all about. And that competition is working.

Plans have no restrictions on the tools they can use to negotiate with drug companies. This was important because one thing we had learned is that the government is not actually very good at figuring out what it should pay for drugs.

The Washington Post recognized this too when it wrote the following in an editorial: "Governments are notoriously bad at setting prices, and the U.S. government is notoriously bad at setting prices in the medical realm."

We knew this because of the government's experience paying for drugs covered under Medicare Part B. These are drugs given during a physician office visit and other drugs like oral cancer drugs. Medicare payments for these drugs were based on what's called the average wholesale price. AWP is like the sticker price for a car. No one actually pays that price. The joke was that AWP actually stood for "Ain't What's Paid."

Over the past decade, reports issued by the Office of the Inspector General, the Department of Justice, and the Government Accountability Office found that by relying AWP, Medicare was vastly overpaying for these drugs.

Recommendations were made to change payments so that they reflected actual market costs. The Clinton Administration tried to make some of these changes, but after push back from providers, it backed off.

Congress took another run at this issue in 2003 in the Medicare Modernization Act and was successful: Congress reformed how Medicare pays for these drugs under Part B. Medicare now bases its payments for many of these drugs on a market-based price. And this change is already saving taxpayers and beneficiaries. But it took years to get fixed and all that time, Medicare and taxpayers paid too much for these drugs. Billions and billions of dollars wasted. I didn't want to repeat that experience under the Medicare drug benefit.

We also knew that Medicare overpays for lots of other services and equipment. The bookshelves are full of other reports from the GAO, the Inspector General, the Medicare Payment Advisory Commission, the Congressional Budget Office and others about how Medicare is paying too much in other areas.

For example, Medicare overpaid for durable medical equipment for years until the Republican-led Congress made changes in 2005 in the Deficit Reduction Act. Each year, the Office of the Inspector General issues its Red Book, which presents cost-saving recommendations. The books are usually 50 or more pages long, and the recommendations span all aspects of Medicare — hospitals, physicians, home health, plans, among others.

This is more evidence on the many areas where Medicare doesn't get the best deal.

Congress even created the Medicare Payment Advisory Commission, or MedPAC as it is known, to provide advice on payments for services. And every year, Congress hears recommendations from the MedPAC to address Medicare overpayments. But many times it takes years for the Secretary of Health and Human Services or for Congress to act. In making recommendations, MedPAC looks at profit margins, for example. One type of provider had been found to have margins of 16 percent. A margin of 16 percent off Medicare payments.

Congress has been able to act on many MedPAC recommendations. But it can be very hard. As Chairman of the Finance Committee, I received letters from members saying "please don't cut payment for this provider group or that provider group."

Like the Clinton Administration found, letters like that can make it really difficult in very short order to do anything about a problem despite compelling evidence of overpayments, despite the high profit margins, despite the fact that a proposed change could save taxpayers billions of dollars.

The architects of the drug benefit were concerned that this same kind of dynamic would happen. Political pressures on the Medicare drug benefit would tie the hands of the Secretary of HHS. If that happened, the program would be unmanageable and costs would skyrocket.

So instead, Congress put competing private plans in charge of the negotiating. These health plans and their pharmacy benefit managers have years of experience in this arena - it's what they do. And HHS has had very little experience and a very dismal track record.

These plans and pharmacy benefit managers have powerful bargaining clout in the market. They manage the drug coverage for tens of millions of people. There are plans that cover upwards of 50 million people; 75 million in one case - far more than the 41 million Medicare beneficiaries.

Now clearly, Medicare beneficiaries account for a large number of all prescriptions filled each year. So some might argue that 41 million beneficiaries have more clout than 75 million non-beneficiaries. But numbers alone do not necessarily translate into lower costs. It's what is done to leverage those numbers that lead to lower costs. That leverage comes from the plan being able to say to a drug company - "I can get better a deal on a different drug that has the same clinical effect made by manufacturer Y. Thanks for your offer, but I'm leaving the table."

Some plans will get a better deal on drug A and put it on their formulary; some plans will get a better deal on drug B. But many experts agree and experience suggests that it would be difficult for the government itself to walk away from the table. There would be enormous pressure to cover everything and if it did, the negotiating power lies with the manufacturers, not with the government.

In fact, in a November 2nd opinion piece in the *Wall Street Journal*, Dr. Alan Enthoven, an economist at Stanford University wrote: "When the government negotiates its hands are tied because there are few drugs it can exclude without facing political backlash from doctors and the Medicare population, a very influential group of voters ." Yesterday's *New York Times* quoted Dr. Alan Garber, the director of the Center for Health Policy at Stanford University on this same subject. Dr. Garber said, "to obtain drugs at low prices, a purchaser must be able to say no to

covering a particular drug." He said that "[i]f you cannot walk away from a deal, there's no way you can be sure of obtaining a low price."

Dr. Garber's point is exactly on point here.

The Medicare drug benefit recognizes that the government would be a weak negotiator. So, it relies on the private sector to do the negotiating. We believed then that the private sector could be a tough negotiator. We had a way to make competition work.

Now when Congress finished work on the new drug benefit in 2003, we knew it was an experiment. Nothing like this had ever been tried.

And here is what we learned: private competition works. It is has been successful at keeping costs down. Plan bids have come in lower than expected. This year, they were down 10 percent from last year's bids. Premiums are lower than they were estimated to be. Before 2006, Medicare's chief actuary estimated that the average monthly premium would be $37. But it was actually $23 in 2006. That is 38 percent lower than expected. And because of the strong competition between plans the average premiums for beneficiaries is expected to be about $22 in 2007.

The net cost to the federal government is also lower than expected. Just today, the official Medicare actuaries are announcing that the net 10-year cost of Part D has dropped by $189 billion over the original budget window used when the MMA was enacted (2004-2013). That is a 30 percent drop in the actual cost compared to the projection. That is unheard of for a government program of any kind.

And states are saving money in lower contributions-better known as "clawback" payments. State clawback payments are now projected to be $37 billion less over a ten year period-that's 27 percent lower. Just in 2006, states saved $700 million.

And the plans are negotiating lower prices for drugs. For the top 25 drugs used by seniors, the Medicare prescription drug plans have been able to negotiate prices that on average are 35 percent lower than the average cash price at retail pharmacies. 35 percent lower. Here are some examples: Lipitor is 15 percent lower, Atenolol is 63 percent lower and Norvasc is 28 percent lower, while Fosamax is 30 percent lower.

Now when the drug benefit was signed into law, we believed it would work and hold down costs. And that is certainly happening today even more than we expected.

We also said that if it did not work-if the negotiating model used for the drug benefit did not hold down costs-then Congress would need to reexamine things. If costs grew too fast then the whole idea would have to be revisited.

Maybe we would have to restrict access to drugs. Maybe we would have to rely more on mail order pharmacies instead of liberal access to local retail pharmacies. Maybe more drastic cost cutting measures would be needed. But that is not the case today.

Everyone has heard the old saying that "if it ain't broke, then don't fix it." And this

certainly applies here and the evidence shows it. Now I would be the first one to say that the Medicare drug benefit is not perfect. There are improvements that can be made. The Senate version of the drug bill had some important features that I hope we can revisit at some point. Congress should look at ways to make it easier for low income beneficiaries to get the additional assistance they need by eliminating the low-income subsidy asset test. We need to look at payments to pharmacies and make some reforms in that area. We need to look at ways we can simplify the enrollment process. And there are other areas where we can make improvements.

But one area that is working very well is the negotiating power of Medicare drug plans. They have shown their ability to hold down costs. It's working.

The pleas from the drug plan's opponents to put the government in charge of negotiating are about politics, not policy. These voices want to score political points with the drug benefit. And it saddens me that we are going to start off this year with the new Democrat-controlled Congress playing politics with Medicare. But that is what this is about. It is about politics. It is not about saving money. And it is not about improving the program.

In fact, the Congressional Budget Office has looked at the proposals to have the Secretary negotiating drug prices and they concluded that they would not achieve any savings. That's right. No savings.

During debate on the Deficit Reduction Act in 2005, Senators Snowe, Wyden, McCain, and Stabenow offered an amendment to give the Secretary authority to negotiate with drug companies. Guess what the Congressional Budget Office said about that amendment. CBO concluded that it would produce zero savings. And the Chief Actuary for Medicare examined the same kind of proposal and came to the same conclusion. He said: "direct price negotiation by the HHS Secretary would be unlikely to achieve prescription drug discounts of greater magnitude than those negotiated by Medicare prescription drug plans responding to competitive forces."

So, Mr. President, I would hope that we could put politics aside here and focus on some of the real improvements we could be making with the drug benefit. That is what we should focus on here. And I still hope that we will. I yield the floor.

As Chairman of the Senate Committee on Finance, Senator Grassley was the principal Senate author of the Medicare Prescription Drug, Modernization and Improvement Act of 2003.

Floor Statement of U.S. Senator Chuck Grassley, of Iowa
"Medicare Part D — History of the Non-Interference Clause"
Senate Committee on Finance
Tuesday, January 9, 2007

Mr. President, I am back again today to talk about the Medicare drug benefit. Yesterday, I spoke about how the benefit uses prescription drug plans and competition to keep costs down and how well that has worked now for the two years of its operation. Today, I will to get to the

crux of this debate: the so-called prohibition on government negotiation with drug makers.

Opponents of the Medicare drug benefit have misrepresented the non-interference clause language. That language doesn't prohibit Medicare from negotiating with drug makers. It prohibits the government from interfering in the negotiations that are actually happening. Much of this debate hinges on a convenient lapse in memories about the history of the non-interference clause.

So today, we are going to take my colleagues on a little trip down memory lane. For our first stop on memory lane, let me read something to you. This is a quote from someone talking about their very own Medicare drug benefit proposal. Under this proposal, Medicare would not set prices for drugs. Prices would be determined through negotiations between the private benefit administrators and drug manufacturers. The person who said this clearly wanted private negotiation with drug companies for a Medicare benefit, not government negotiation. He was proposing, and I quote again, "negotiations between private benefit administrators and drug manufacturers." It couldn't be more clear than that.

You are going to be shocked to hear who said this. The quote is from none other than President Clinton. President Clinton made that comment as part of his June 1999 plan for strengthening and modernizing Medicare for the 21st century. President Clinton went on to say that under his plan, again quoting, "[p]rices would be determined through negotiations between the private benefit administrators and drug manufacturers." Quoting further, he said "The competitive bidding process would be used to yield the best possible drug prices and coverage, just as it is used by large private employers and the Federal Employees Health Benefit Plan today."

President Clinton also described his plan as using private negotiators as opposed to government negotiators because "[t]hese organizations have experience managing drug utilization and have developed numerous tools for cost containment and utilization management." Does this ring any bells?

It should, because it's the same framework used in today's Part D Medicare prescription drug benefit. Private negotiation with drug companies and it's based on the nearly 50 year history of the Federal employees health plan.

And, here is another interesting spot on memory lane for you history buffs, the Clinton plan had a coverage gap-a donut hole-just like the eventual bill signed into law in 2003. And, like many others, the brand new Speaker of the House has questioned why one would pay premiums at a point in time when you are not receiving benefits as is the case with the donut hole. Well, that's how insurance works.

Go look at any homeowners policy, auto insurance policy or even in Part B of Medicare. You pay premiums to have the coverage. And that is also how President Clinton's plan was meant to work.

In Sunday's Washington Post, Speaker Pelosi was quoted on her thoughts about having a donut hole. She said, "how could that be a good idea unless you're writing the bill for the HMOs and the pharmaceutical companies and not for America's seniors." Now, was she referring to

President Clinton's plan, proposed in June of 1999?

As I said, President Clinton proposed this plan in June of 1999. On April 4, 2000, S. 2342 was introduced here in the Senate. S. 2342 would have created a drug benefit administered through private benefits managers. So, here again, private negotiations with drug companies. Sound familiar? It's just like today's Medicare drug benefit that is law.

And here is another important stop during our trip down memory lane. This bill, S. 2342 included the following language, and I quote: "NONINTERFERENCE- Nothing in this section or in this part shall be construed as authorizing the Secretary to authorize a particular formulary or to institute a price structure for benefits, or to otherwise interfere with the competitive nature of providing a prescription drug benefit through benefit managers."

This is the first bill- the very first one - where the non-interference clause appeared. This is the first prohibition on government negotiation that was proposed. But S. 2342 wasn't introduced by a Republican. It was introduced by my esteemed colleague, the late Senator Moynihan.

One month later S. 2541, the MEND Act, was introduced. Let me read you some language from that bill. "Noninterference - In administering the prescription drug benefit program established under this part, the Secretary may not - (1) require a particular formulary or institute a price structure for benefits; (2) interfere in any way with negotiations between private entities and drug manufacturers or wholesalers; or (3) otherwise interfere with the competitive nature of providing a prescription drug benefit through private entities."

That wasn't a Republican bill either. It was introduced by Senator Daschle who was joined by 33 other Democrats including Senators Reid, Durbin, and Kennedy. That's right-33 Senate Democrats cosponsored the bill.

You see, it turns out that the Democrats didn't want the government, nor did President Clinton, interfering in the private sector negotiations either. They recognized then that the private sector would do a better job and they didn't want the government messing it up.

In June 2000, two Democratic bills were introduced in the House of Representatives that also included noninterference language. H.R. 4770 was introduced by then Democratic Leader, Dick Gephardt. That bill had more than one hundred Democrat cosponsors including the new Speaker of the House and Representatives Rangel, Dingell, and Stark. The prohibition on government negotiation included in H.R. 4770 was almost identical to the language in Senator Daschle's bill.

Now here is the text of the actual noninterference clause that was included in the Medicare Modernization Act signed into law in 2003: NONINTERFERENCE- In order to promote competition under this part and in carrying out this part, the Secretary-

1. may not interfere with the negotiations between drug manufacturers and pharmacies and PDP sponsors; and
2. may not require a particular formulary or institute a price structure for the reimbursement of covered part D drugs.

Sounds quite a bit alike doesn't it?

Last week, the senior Senator from Illinois described the 2003 Medicare law as being written by the pharmaceutical industry. But the non-interference clause first appeared in legislation introduced by Democrats who now oppose the same provision that's in the present law. Now the opponents of the Medicare drug benefit always say that the noninterference clause is proof that the drug industry wrote that law. My question is, if that's what you think, did the pharmaceutical industry write yours?

Now I bet you are wondering just how many Democrat bills had the now-infamous non-interference clause-the prohibition on government negotiating. Well, here is the whole timeline.

As you can see here, that prohibition on the government negotiating-the non-interference clause-has been in 7 bills by Democrats between 1999 and 2003, including a bill introduced in the House on the same day as H.R. 1, the bill that became law.

Well, there were seven. And here they all are on this chart. First it was in the Moynihan bill, then there was the Daschle-Reid-Kennedy bill. That was followed in the House by a bill introduced by Representative Eshoo, and then the Gephardt-Pelosi. Representative Stark then had his own bill. The senior Senator from Oregon then introduced his bill in Senate. Finally, over in the House, Representative Thompson of California introduced a bill with the same prohibition. Now it seems to me that on the other side of the aisle, there should be some consideration of where this provision came from.

Now I know what the response will be. It will be that even though Democratic bills had nearly the exact same prohibition on government negotiation - practically word for word in seven bills over a long period - opponents now think that approach is no longer the best for Medicare.

Sort of like we supported it before we opposed it. Beneficiaries and the public deserve more than that. I yield the floor.

As Chairman of the Senate Committee on Finance, Senator Grassley was the principal Senate author of the Medicare Prescription Drug, Modernization and Improvement Act of 2003.

Floor Statement of U.S. Senator Chuck Grassley, of Iowa
"Medicare Part D — How Would the Government Negotiate?"
Senate Committee on Finance
Wednesday, January 10, 2007

Mr. President, I am back again today to talk about the Medicare drug benefit and the debate about whether the government would do a better job negotiating with drug companies than the prescription drug plans are doing today.

Over the past two days, I've talked about the fundamental structure of the drug benefit. The heart of that structure is competition. Plans with vast experience in negotiating with drug manufacturers compete to get the best drug prices for Medicare. And to date, we have lower bids, lower beneficiary premiums, lower costs to the government, lower costs to states. Most

importantly, we have lower prices on drugs.

Let me give you some examples. A draft Price Waterhouse Coopers study found that in 2006, prescription drug plans achieved higher savings - 29 percent compared to an unmanaged drug benefit expenditures. That's almost 100 percent greater than the 15 percent savings projected by the Centers for Medicare & Medicaid Services and almost 50 percent greater than the savings estimated by the Congressional Budget Office.

Competition is working.

Yesterday, I talked about how this whole debate is based on nothing more than a distortion of language in the non-interference clause - language that was first included in legislation introduced by many of the same people who now oppose it. To be clear, that language does not prohibit negotiation. Negotiations occur between the private plans and the drug manufacturers. You couldn't get the lower prices I just mentioned without negotiation.

I also pointed out that, so far at least, proposals to have the Secretary of HHS negotiate drug prices have not been shown to actually save any money. But nevertheless, here we are in the new Congress discussing this matter.

What I want to do today is put forward a picture of what government negotiation might look like. Doing this will require some speculation. Why is that necessary? Well, it's necessary because Democrats have not provided many details on how they actually envision their requirement that the Secretary negotiate will actually work. This is despite the fact that some opponents of the non-interference clause have demagogued on this issue for nearly three years. But they have given us a few clues as to their thinking on how they want this to work. For the longest time, I've heard it said that the Secretary of Health and Human Services should have the power to negotiate drug prices like the Veterans Administration does. So, with that as our guide, let's talk about the VA.

And this discussion is going to be somewhat technical, but I urge you to bear with me because we need to get beyond the VA sound bite. Everyone needs to have a good understanding of what this would mean for Medicare.

It is a fact that the VA uses different purchasing arrangements to get discounts on prescription drugs. But there is a big distinction between these purchasing arrangements. The VA has access to Federal Supply Schedule prices. Under the Federal Supply Schedule, the government guarantees by law that it must get the best price in the marketplace. What this means is that the federal supply schedule prices cannot exceed the lowest price that a manufacturer gives under comparable terms and conditions to a non-federal customer, like a health plan or pharmacy benefits manager. Under federal law, manufacturers must list their drug on the Supply Schedule to qualify for reimbursement under Medicaid.

Next, the VA can purchase drugs at the Federal Ceiling Price. Again, the government passed a law to guarantee itself an automatic discount no one else can get. By law, that price is automatically 24 percent less than the average price paid by basically all non-federal purchasers. Nice negotiating tactic, pass a law and guarantee yourself a discount.

The logical questions are: "Why not have Medicare access the Federal Supply Schedule? Why not give Medicare the Federal Ceiling Price?"

Experts have looked at this question. Here's what the Government Accountability Office said in a 2000 report: "Mandating that federal prices for outpatient prescription drug be extended to a large group of purchasers, such as Medicare beneficiaries, could lower the prices they pay, but raise prices for others."

You heard that right. Raise prices for everyone else. Who would face those higher prices? Small businesses, their employees, and their families, just to name a few. Those higher prices would likely force employers to reduce their prescription drug benefit or stop providing health insurance coverage altogether. That's an outcome that I surely hope people would want to avoid.

The GAO reached its conclusion by examining what happened to drug prices after Congress required drug manufacturers to pay rebates to state Medicaid programs. Like the federal supply schedule, the Medicaid rebate program guarantees that the government gets the best price in the marketplace. So what happened after that law was enacted? The best prices went up for everyone else. The practical effects were twofold. First, the size of rebates for state Medicaid programs got smaller. Second, other purchasers paid higher prices.

Why is that you might ask? Here's why. Drug makers had to eliminate their best prices to private purchasers or face bigger rebates. That happened because if they gave just one purchaser a best price, they then had to give that best price to 50 state Medicaid purchasers. So one discount to a private purchaser could mean millions of dollars that a manufacturer would be forced to pay in rebates to the government. So the drug companies eliminated all those deep discounts so they didn't have to pay as much in mandatory rebates to Medicaid.

A 1996 study by the non-partisan Congressional Budget Office examined the extent to which the Medicaid law resulted in higher drug prices for everyone else. The Congressional Budget office concluded that "best price discounts have fallen from an average of more than 36 percent in 1991 to 19 percent in 1994. Hence, although the Medicaid rebate appears on the surface to be attractive, it may have had unintended consequences for private purchasers." An almost 50 percent reduction in best price discounts. A nearly 50 percent reduction in the discounts received by purchasers such as health plans that serve employers and their employees.

What this means is that when those deep discounts went away, the price that everyone else pays for drugs went up. So those mandated rebates to Medicaid made drug prices for everyone else higher. To state it more simply, when discounts to a large purchasing group are based on discounts to another, no one really gets a good discount. And that's exactly what the GAO said in its 2000 report: "…extending the Federal Supply Schedule . . . could also raise the prices paid by private and federal purchasers, as increases in the prices manufacturers charged their best customers would, in turn, increase Federal Supply Schedule prices."

Ironic, isn't it? When the government uses price controls to mandate discounts to itself, it makes actually makes prices go up.

During a 2001 hearing before the Senate Committee on Veterans Affairs, my colleague,

the senior Senator from Pennsylvania, posed a question on this very matter. He asked whether adding Medicare to the VA and Department of Defense purchasing mix would produce greater bulk discounts. The VA Chief Consultant for its Pharmacy Benefits Management Strategic Health Group answered that adding Medicare to the Federal Supply Schedule umbrella would result in increased drug prices for the VA and DoD.

So now, in addition to the GAO and the CBO, straight from the VA's mouth itself - extending VA's prices to Medicare would make the VA's own drug prices increase. The basic point they are making is that if you try to mandate discounts to everyone then no one gets a discount. Now, I am no economist, but this is basic economics. And not only that, it's common sense.

I think I've pretty much laid out why including Medicare in the federal supply schedule is not as good an idea as its proponents have made it out to be. Now I want to turn back to how the VA uses competitive bidding to get discounts. And let me start by giving you an important piece of information.

The VA has its own pharmacy benefits manager.

More than a decade ago, as part of a major initiative to improve the care it delivered, the VA formed a pharmacy benefits manager, better known by many as a PBM.

Why did it do that? Because as stated in a VA news release, it wanted to maximize a strategy used by the private sector. A primary responsibility of the VA's PBM was to develop a national formulary. That's right - a national formulary. A formulary is the list of drugs that a plan will cover. Basically, if your drug is not on the list, it is not covered.

A 2005 article in the American Journal of Managed Care co-authored by VA staff and university-based researchers stated that the VA created the national formulary to achieve two main goals. First, the VA wanted to reduce variation in access to drugs across its many facilities. The wanted to out a VA beaurcrat between the patient and the doctor. Second, it wanted to use the VA's formulary as leverage to get lower prices for drugs.

Let me repeat that because it's an important point. The VA created a national formulary to create the leverage it needed to get lower prices for drugs.

This goes back to the point I made a couple of days ago. The ability to get good discounts does not result from the sheer number of people a purchaser buys for. The ability to get good discounts comes from how the purchaser leverages those numbers. That leverage comes from a purchaser threatening to exclude a drug from the formulary. The VA uses its formulary to say give me a better price or else-we are not buying your drug at all.

As I said earlier, the VA was intentionally adopting a private-sector strategy when it started using a formulary to get lower drug prices. The Medicare prescription drug plans also use formularies to negotiate lower drug prices. The most important thing about the VA formulary is that it is one big national formulary. The biggest difference between the VA and Medicare is that beneficiaries have choices. They can choose different plans with different formularies. They can enroll in a plan that covers their drugs. The can enroll in a plan that allows them to use their

neighborhood pharmacy. And the VA doesn't do business with every pharmacist in America so you're hurting your local pharmacists when you do business that way.

Under the VA program, veterans can't choose a different plan and they have to use the VA's own pharmacy - not the retail pharmacy down the street. Using a limited number of VA-controlled pharmacies and mail-order pharmacies also helps keep VA costs down. Limited access to drugs. Limited access to retail pharmacies. That's how the VA works.

The *Los Angeles Times* put it best in an article on November 27th of last year. You can see it on this chart. According to the *LA Times* story, "VA officials can negotiate major price discounts because they restrict the number of drugs on their coverage list . . . In other words, the VA offers lower drug prices but fewer choices." That's not what we wanted when we developed the Medicare benefit.

So what would it mean if the government negotiated for lower drugs prices for Medicare in a national system like the VA? It would mean having a more limited formulary. This chart shows what that would mean. It would mean that instead of having 4,300 drugs available to them, beneficiaries would have about 1,200. If Medicare used a national formulary like the VA it would mean that 70 percent of prescription drug could not be covered by Medicare. Only 30 percent of the drugs covered today would be covered.

And what about drugs for diabetes or cholesterol? There too, if the government negotiated for Medicare like it does for VA, it would mean fewer drugs covered by Medicare. This chart compares the drugs that Medicare covers for diabetes and cholesterol with those covered by the VA. If the government used the VA model for negotiating, 46 percent fewer cholesterol drugs would be covered and 35 percent fewer drugs for diabetes would be covered. And in many cases, those realities have led Medicare-eligible veterans to enroll in the Medicare drug benefit so that they'll have coverage for drugs not covered by the VA.

That's right. Even though many veterans have very good drug coverage, almost 40 percent of veterans with VA benefits and Medicare coverage are enrolled in Part D. So when you get beyond the easy sound bites, when you get to the facts, applying the VA system to Medicare is neither as easy as it sounds nor will it likely have the effect that its proponents suggest. And it now appears that even they have begun to figure this out. Because now, when the rubber hits the road, when they have to produce something, they introduce a bill - and I'm referring to a bill in the other body - that explicitly prohibits the Secretary from creating a formulary.

In fact, the *Los Angeles Times* reported last week that a House Democratic Leadership Aide said, "We felt we couldn't go as far as Veterans Affairs does." Under the House Democrats bill, Medicare can't have a formulary. And as I have tried to make clear here today, the drug formulary is the key to negotiating lower drug prices. The House Democrats' bill prohibits the government from having a national formulary. No formulary means no negotiation. No leverage over drug companies. In reality, the Democrat proposal on negotiation actually prohibits the government from negotiating.

Under their plan for government negotiation, the government won't be able to say no to a drug company. With no formulary to bargain with, the drug company could say "No, why should

I give you that price if you can't exclude me or charge higher cost-sharing?" At the same time, the House Democrats' bill repeals the prohibition on the government setting a pricing structure.

So if the government cannot negotiate because it can't have a formulary, if there is no prohibition on a government price structure, where does that leave us? Sounds like prices controls to me. And experience shows that when the government sets prices for itself, when it gives itself a mandatory discount, prices go up for everyone else. Higher prices for everyone else.

Why would anyone want that?

Now, everyone always asks why not have the Medicare work like the VA to get lower drug prices. I think I've laid out why that idea might not be as good as its proponents have made it out to be. Having Medicare work like the VA could mean: fewer drugs covered; restricted access to retail pharmacies; more use of mail order pharmacies; and higher drug prices for everyone else.

I just can't imagine the that's what people really want. So where does that leave us? The Medicare plans are working today. They are delivering the benefits to Medicare beneficiaries. These private-sector plans have the experience in negotiating better prices. These Medicare negotiators have proven their ability to get lower prices. The Medicare plans are negotiating with drug companies using drug formularies within the rules set in law.

Last week on the Senate floor, the senior Senator from Illinois said that the law "took competition out of the program so that [the drug companies] could charge what they want." "Took competition out of the program?" Competition is what this program is all about. And that competition is working. Costs are lower. Premiums are lower. These organizations remain in the best position to get lower prices for Medicare beneficiaries and taxpayers. Mr. President, I yield the floor.

Floor Statement of U.S. Senator Chuck Grassley, of Iowa
"Medicare Part D — What the Experts and Others Are Saying"
Senate Committee on Finance
Thursday, January 11, 2007

Mr. President, over the past few days, I have stood before you presenting information about the Medicare prescription drug benefit. On Monday, I spoke about how the benefit uses prescription drug plans and competition to keep costs down and how well it is working. I said it then and I'll say it again, "If it ain't broke, don't fix it." I presented findings from the Chief Actuary at CMS and from experts at the Congressional Budget Office explicitly rejecting opponents' claims that giving the Secretary the authority to negotiate with drug companies would produce savings. Well, today I am going to let the words of others from across the political spectrum and from the news media do the talking.

I'll begin with Secretary Michael Leavitt of the Department of Health and Human

Services who said, quote, "Government negotiation of prices does not work unless you have a program completely run by the government. Federal price negotiations would unravel the whole structure of the Medicare drug benefit, which relies on competing private plans." Just today, the Secretary wrote in an op-ed for the *Washington Post* that if the government was required to negotiate that mean that, quoting the Secretary, he said, "one government official would set more than 4,400 prices for different drugs, making decisions that would be better made by millions of individual consumers." He went on to say that, again quoting, "there are many ways the administration and Congress can work together to make health care more affordable and accessible. But undermining the Medicare prescription drug benefit, which has improved the lives and health of millions of seniors and people with disabilities, is not one of them."

Next, we have Dan Mendelson, a former Clinton Administration official, who now is President of a healthcare consulting firm that tracks the Medicare prescription drug program. He says, "From a rhetorical perspective, Democrats may feel like they gain a lot with this issue, but there are many substantive hurdles that the government faces in trying to negotiate prices. If you look historically at the government's experience in trying to regulate prices, it's poor."

As supporting evidence, a *Chicago Tribune* editorial said the following, "Richard S. Foster, the chief actuary for the Centers for Medicare and Medicaid Services (CMS), studied whether direct government negotiation would yield bigger discounts. His answer: Not likely. One reason, he said, was "Medicare's unreassuring record on price negotiations before the new benefit was passed. Medicare has a history of paying for some drugs 'at rates that, in many instance, were substantially greater than the prevailing price levels.' Translation: The feds got fleeced."

In November, the *Washington Post* printed a quote from Marilyn Moon, director of the health program at the American Institutes for Research. She is a former trustee of the Social Security and Medicare trust funds, a former senior analyst at the Congressional Budget Office, and current President of the board of the Medicare Rights Center. She said, "Government price negotiation is much more of a morass than people think. It is a feel-good kind of answer, but it's not one that is easy to imagine how you put it in practice." Dr. Alain Enthoven, Professor Emeritus at Stanford University is an expert on health care financing. He wrote in an opinion piece that appeared in the *Wall Street Journal*, "When the government negotiates its hands are tied because there are few drugs it can exclude without facing political backlash from doctors and the Medicare population, a very influential group of voters. Quoting further, he said "Congressional Democrats need to be careful in making the logical leap from market share to bargaining power. Empowering the government to negotiate with pharmaceutical companies is not necessarily equivalent to achieving lower drug prices. In fact, neither economic theory nor historical experience suggests that will be the outcome."

An editorial in the *Dallas Morning News* echoed my statement from Monday that beneficiaries do not want the government in their medicine cabinets. Here's a quote from that editorial: "Giving the feds the power to negotiate drug prices for seniors would effectively cede control of the pharmaceutical industry to Washington. When congressional Democrats press for this change, remember they're pushing for much more than lower prices. They're seeking to move the line where government should stop and the marketplace should start." But let's talk about who really matters in this case, the beneficiaries and taxpayers. In 2006, premiums were 38 percent lower than originally estimated. The net cost to the federal government is lower than

expected. The 10-year cost of Part D has dropped $189 billion, representing a 30 percent drop in the actual cost compared to the original projections. For the top 25 drugs used by seniors, the Medicare prescription drug plans have been able to negotiate prices that on average are 35 percent lower than the average cash price at retail pharmacies.

A poll of Medicare beneficiaries by J.D. Power & Associates, which takes consumer temperatures on all sorts of products, found that 45 percent of the beneficiaries surveyed were "delighted" with the Medicare drug benefit. They gave their own drug plan a "10" on a 10 point-scale. And another 35 percent of those surveyed gave their prescription drug plan an 8 or a 9 rating on that 10-point scale. And other polls are consistent. So that's eighty percent satisfied.

All of the program's successes have been challenged at various times by the program's opponents and each time they are proven wrong. As the plan continues to return positive results, skeptics are beginning to change their opinion as well. Dr. Robert Reischauer, a former director of the Congressional Budget Office, is a nationally known expert on Medicare. Currently, he is president of the Urban Institute and serves as Vice Chair of the Medicare Payment Advisory Commission. "Initially, people were worried no private plans would participate. Then too many plans came forward. Then people said it's going to cost a fortune. And the price came in lower than anybody thought. Then people like me said they're low-balling the prices the first year and they'll jack up the rates down the line. And, lo and behold, the prices fell again. At some point you have to ask: What are we looking for here?"

Now let me tell you what newspapers are saying.

A *Washington Post* editorial represented an insightful viewpoint, saying, quote, "A switch to government purchasing of Medicare drugs would choke off this experiment before it had a chance to play out, and it would usher in its own problems. For the moment, the Democrats would do better to invest their health care energy elsewhere."

A *USA Today* editorial took it a step further, saying, "A deeper look, however, suggests that the Democrats' proposal was more of a campaign pander than a fully baked plan…governing is different than campaigning. The public would be best served if the new Congress conducts in-depth oversight to gather the facts, rather than rushing through legislation within 100 hours to fix something that isn't necessarily broken."

And finally, put simply by *The National Review*, government negotiation, quote, "is a solution in search of a problem and could unnecessarily disrupt a benefit that is working well for seniors."

What compounds the problem is the fact that neither I nor anyone else has heard Democrats explain how government negotiation would work.

A *The New York Times* news article from this past Sunday said, the Democrats' proposal in H.R. 4 is seen by "many economists and health policy experts…as a paradox." On the one hand, the Democrats want the government to negotiate lower drug prices for Medicare beneficiaries, but on the other hand, they insist that the government should not decide which drugs are covered. Continuing the paradox, and I'm quoting the *New York Times* article, "the bill says the secretary 'shall negotiate' lower prices. On the other hand, the drug benefit would still be

delivered by private insurers. Each plan would establish its own list of covered drugs, known as a formulary, and the secretary could not 'establish or require a particular formulary.'"

In the same *New York Times* story, James R. Lang, former President of Anthem Prescription Management, a drug benefit manager said, "For this proposal to work, the government would have to take over price negotiations. It would have to take over formularies. You can't do one without the other. Drug manufacturers won't give up something for nothing. They will want a preferred position on the Medicare formulary - some way to increase the market share for their products."

The only comparison I know of is the Veterans Administration. So, when people come up to me and ask why the government negotiates for veterans and not for seniors I tell them what a Medicare system modeled after the VA would look like. Yesterday, I spent some time explaining what government negotiation looks like for the VA and other federal programs. But, again, instead of listening to my words, I will tell you what others are saying.

As explained in the *Washington Post*, and I quote, "The veterans program keeps prices down partly by maintaining a sparse network of pharmacies and delivering three-quarters of its prescriptions by mail...Moreover, the program for veterans is in a position to negotiate hard with drugmakers because it can credibly threaten not to buy from them: Its plan excludes many new medicines."

The *Los Angeles Times* continues the discussion, stating, "Applying the VA approach to Medicare may prove difficult. For one thing, Medicare is much larger and more diverse. VA officials can negotiate major price discounts because they restrict the number of drugs on their coverage list. Instead of seven or eight drugs for a given medical problem, the VA list may contain three or four. If a drug company fails to offer a hefty discount, its product may not make the cut."

Mr. President, the final thoughts I will leave you with today come from a letter sent by the non-partisan Congressional Budget Office.

Just yesterday, after reviewing H.R. 4 at the request of Congressman Dingell, the Chairman of the Committee on Energy and Commerce, the Congressional Budget Offices concluded the following, and here I am quoting again: "H.R. 4 would have a negligible effect on federal spending because we anticipate that the Secretary would be unable to negotiate prices across the broad range of covered Part D drugs that are more favorable than those obtained by PDPs under current law." The letter continued to say, quote, "without the authority to establish a formulary, we believe that the Secretary would not be able to encourage the use of particular drugs by Part D beneficiaries, and as a result would lack the leverage to obtain significant discounts in negotiations with drug manufacturers." In conclusion, CBO's letter to Mr. Dingell said, quoting again, "the PDPs have both the incentives and the tools to negotiate drug prices that the government, under the legislation, would not have." I think that pretty much sums it up. I can think of nothing more to say that CBO did not say in its letter on H.R. 4.

And so, Mr. President, as I have said before this week, I would hope that we could put politics aside here and focus on some of the real improvements we could be making with the drug benefit. That is what we should focus on here. And I still hope that we will.

Mr. President, I yield the floor.

Floor Statement of U.S. Senator Chuck Grassley, of Iowa
"Medicare Part D — The Debate on Government Negotiation, A Week in Review"
Senate Committee on Finance
Tuesday, January 16, 2007

Mr. President, on four days last week, I talked about the Medicare prescription drug benefit and the so-called prohibition on government negotiation with drug makers for low prices. I spent time doing that because people need to understand that some proposals could have drastic consequences not only for Medicare beneficiaries, but also for anyone else who buys prescription medicines.

In other words, if we change Medicare it will increase the price of prescription drugs for everybody.

I've said it before and I'll say it again: having the government negotiate drug prices for Medicare might be a good sound bite, but it's not sound policy. H.R. 4, the bill passed by the House last week, falls into that category. It's a good sound bite, but not sound policy. It will be bad for Medicare beneficiaries and other consumers of prescription medicines. No one will win.

That outcome was voiced by witnesses who testified before the Senate Finance Committee last Thursday. First, Dr. Fiona Scott Morton, a Professor of Economics at Yale University, made a key point about the size of the Medicare market. She pointed out that of course, we all want to obtain discounts on drugs for seniors. But, she said, and I'm quoting: "With close to half of all spending being generated by those seniors, whatever price they pay will tend to be the average price in the market." Her point was that if you're half the market, the math makes it virtually impossible for your prices to be below the average.

Professor Scott Morton said that because Medicare is so large, if drug makers had to give it the lowest price they give any customer, they'd have a strong incentive to increase their prices for everyone else. Professor Morton also stated, and I quote: "This approach to controlling prices harms all other consumers of pharmaceuticals in the United States and is bad policy." So, it's "great" to help seniors, but there is no free lunch. Everybody, regardless of age, will pay more for prescription drugs.

Do you want to do that?

A representative of the non-partisan Government Accountability Office (GAO) talked about its 2000 report on this issue, and echoed Dr. Scott Morton's view. Remember, in 2000, the GAO concluded, "Mandating that federal prices for outpatient prescription drugs be extended to a large group of purchasers, such as Medicare beneficiaries, could lower the prices they pay, but raise prices for others."

One thing we keep hearing is that Medicare should not pay more than the VA pays. Dr. Richard Frank, an economist from Harvard University, said that if Medicare got the same prices that the VA gets drug makers would likely raise VA prices for all drugs. Do you want to hurt veterans? As they listened to Dr. Frank's response, other panelists nodded in agreement. Talk

about unintended consequences. And you know who else agrees with that? The Military Order of the Purple Heart.

In a letter to Members of Congress, the Military Order of the Purple Heart expressed their concern about the impact that extending VA prices to Medicare could have. In fact, they stated that several veteran organizations have passed formal resolutions opposing legislation to extend VA prices to Medicare because it would threaten the VA's current discounts. So, higher drug prices for the VA.

Another key point made at last week's hearing was that it's not simply about the number of people you're buying prescription drugs for. In response to a question I asked, Professor Scott Morton said it doesn't matter whether you negotiate on behalf of one million people or 43 million people. What matters is what leverage you have and how you use it. And if you don't have a fundamental tool, and that would be a formulary, you have no leverage over drug makers. A formulary is a list of drugs that a plan will cover. Here's what Professor Scott Morton said would happen if someone negotiating drug prices couldn't have a formulary: “Each manufacturer would know that, fundamentally, Medicare must purchase all products. The Medicare 'negotiator' would have no bargaining leverage, and therefore, simply allowing bargaining on its own would not lead to substantially lower prices."

Mr. Edmund Haislmaier, a fellow with the Heritage Foundation, talked about the limits of bulk purchasing power alone. In his written testimony, he said, and I am quoting, "[that] volume purchasing encourages manufacturer discounting, it is not, in and of itself, sufficient to extract large discounts. Manufacturers will only offer substantial discounts if the buyer combines the 'carrot' of volume with the 'stick' of being able to substitute one supplier's goods with those of another." In drug negotiations, that stick is a formulary.

Mr. President, H.R. 4, the bill that was considered in the House last Friday, prohibits the Secretary from using a formulary. Thus, the stick that's necessary that the VA uses to drive down the price of drugs is not even in the House-passed bill that's supposed to guarantee senior citizens lower drug prices. So for all their talk about getting savings from government negotiation, the House Democrats took away the key tool to get lower prices.

That was a key lesson from last week's Finance Committee hearing. And here's what the Congressional Budget Office said about H.R. 4. H.R. 4 would have "a negligible effect on federal spending." Let me repeat that: "a negligible effect on federal spending." The CBO said, “Without the authority to establish a formulary, we believe that the Secretary would not be able to encourage the use of particular drugs by Part D beneficiaries, and as a result would lack the leverage to obtain significant discounts in his negotiations with drug manufacturers."

That statement's pretty clear: what we're being told will happen as a result of the House-passed bill - and that would be lower prices - isn't going to happen. Here's what the independent actuaries at CMS, which oversees the Medicare drug benefit, said about H.R. 4: "Although the bill would require the Secretary to negotiate with drug manufacturers regarding drug prices, the inability to drive market share via the establishment of a formulary or development of a preferred tier significantly undermines the effectiveness of the negotiation." So whether you're CBO working for the Congress of the United States or whether you're the independent actuaries at the Centers for Medicare & Medicaid Services, you reach the same

conclusion. And that conclusion is that the House Democrats' legislation will not be effective because it prohibits the use of a formulary.

So why not have the Secretary establish a national formulary? Let me point out the key downside of having the Secretary establish a national formulary. Fewer drugs would be covered. If Medicare used a formulary like the VA's, it would mean 70 percent of drugs available today in Medicare would not be covered.

So let me sum up two important points from the hearing and from the experts at the Congressional Budget Office and from Medicare's Chief Actuary. First, giving Medicare the lowest price that a drug maker gives any purchaser - whether that be a private plan or the VA - will increase prescription drug prices for everyone else. That means higher prices for working Americans and small businesses. Second, the ability to use a formulary, to negotiate, you have to be able to tell a drug maker that if you don't give me a good price, I'll pick another drug to put on my formulary. If you don't believe all of these experts, if you don't believe all of these people who have studied this over a long period of time, who are you going to believe?

Now, I want to go back and remind everyone where the prohibition on negotiation came from. That's the non-interference clause. The opponents of the drug benefit seem to conveniently forget that their own bills had the same language and that they supported a benefit run by private plans. In fact, the prohibition of government negotiation- the non-interference language - first appeared in a Democratic bill. In total, seven bills introduced and supported by 34 Senate Democrats and more than 100 House Democrats had the prohibition in them. On top of that, many of the people who are now twisting that language around cosponsored those bills.

I also want to point out that even President Clinton's proposal to create a Medicare prescription drug benefit took the same approach. President Clinton said so many good things about having private plans negotiate lower drug prices for Medicare beneficiaries that I didn't have to think up new things to say. I just need to repeat what President Clinton said about saving money, about the ability of plans to negotiate, and about ensuring seniors have a wide range of prescription medicines available to them.

Mr. President, let me wrap up by going back to where I started last week. The Secretary does not need the authority to negotiate. And a national formulary is a bad idea. Competition among plans is leading to lower drug prices for beneficiaries and lower costs for taxpayers and states. Premiums are lower than they were estimated to be. Before 2006, Medicare's chief actuary estimated that the average monthly premium would be $37. But it was actually $23 in 2006. That is 38 percent lower than expected. And because of the strong competition between plans the average premiums for beneficiaries is expected to be about $22 in 2007.

Competition is working.

The net cost to the federal government is also lower than expected. Last week, the official Medicare actuaries announced that the net 10-year cost of Part D has dropped by $189 billion over the original budget window used when the MMA was enacted (2004-2013). That is a 30 percent drop in the actual cost compared to the projection.

Competition is working.

When else have you heard of a cost underrun in a federal program. Probably never. And you couldn't get those lower prices and lower costs unless the prescription drug plans are being strong negotiators with the drug makers.

Competition is working.

Now, I know that opponents of the drug benefit will likely keep up their attacks on the program. But I have been working hard this past week to give people some important facts that have been left out of the debate on government negotiation. The plain and simple fact of the matter is that competition among the plans is working. The Medicare plans are delivering the benefits to Medicare beneficiaries. These private-sector plans have the experience in negotiating better drug prices.

As I pointed out last week, for 50 years plans have been negotiating lower prices under the Federal Employees Health Benefits Program. The FEHBP has been successful, and that why we modeled the Medicare prescription drug benefit after it. These Medicare negotiators have proven their ability to get lower drug prices. The Medicare plans are negotiating with drug companies using drug formularies within the rules set in law. And these plans have to be approved by CMS. Medicare beneficiaries have access to the drugs they need.

And on that point, I'll give you just one example. Let me share with you the views of the ALS Association. ALS is Lou Gehrig's disease. Here's what they said about repealing the non-interference clause in a January 4th letter to Members of Congress. “The elimination of the non-interference provision will have particularly cruel consequences for people with ALS." The Association went on to say that, "It means that even if a new drug is developed to treat A-L-S, many patients likely will not have access to it. That's because price controls can limit access to the latest technologies." The letter goes on to say that individuals with ALS, "will either be forced to forego treatment, or only have access to less effective treatment options - ones that may add a few months to their lives, but not ones that will add years to their lives." Just for the record, drugs to treat ALS are covered under the Medicare drug benefit.

Mr. President, I want to close by saying what I said on Monday benefit: "if it ain't broke, don't fix it." Competition is working. I ask unanimous consent that the letters that I referred to be included in the record.

I yield the floor.